
PERONEAL TENDINITIS PROTOCOL

Peroneal tendinitis, an irritation to either one or both of the major peroneal tendons, may be secondary to many etiologies including: remote trauma, excessive, repetitive forces during waking, standing, high arched foot, poor or quickly increased training, hind foot various positional, and/or improper footwear. The peroneal tendons assist with lateral ankle stability and may be needed to be addressed with patients with history of multiple ankle sprains. Most patients can be treated successfully with a conservative approach. Long term situations where patients have failed to improve with conservative management or acute severe tearing or rupture of the tendons most likely require surgical intervention.

When therapy and anti-inflammatories fail to adequately alleviate pain and instability, surgery may be necessary. This is the repair or reconstruction of the tendons on the outside of your ankle. The peroneal tendons often tear along their fibers; they rarely rupture. Think of a peroneal tendon tear as cutting a piece of linguine pasta into 2-3 strands of “angel hair” spaghetti. If the tendons have a very small tear or simply tendinitis, this tear may be simply excised. If there is a moderate tear, this may be repaired by sewing the tendon edges together. A more severe tear may entail excision of the torn piece and a tendon transfer of one tendon to its neighbor. The most significant tears further may require an allograft, or “cadaver tendon”, to reconstruct.

In addition to tendon repair, the fibula (outside ankle bone) may need to be cut to allow more room for the tendons to sit within the groove without dislocating. Further, occasionally correction of the bones around the foot are sometimes needed; see the “Cavus Foot Reconstruction” worksheet for that overview.

Please note that these are rough guidelines and your individual surgery may require a postop course tailored to your needs.

Physical Therapy Non-Operative Protocol

- If significant pain is present, CAM walker or ankle bracing may be used to decrease pain, along with use of NSAIDS, icing, avoiding activities such as cutting or changing direction.
- Immediate start AROM, calf stretching, normalizing gait mechanics, manual therapy when needed if patient has been immobilized.
- Limited modalities as appropriate for pain and/or edema management including: phonophoresis, electrical stimulation, kinesiostaping.
- Initiate strengthening of foot/ankle with isometrics, theraband, closed chain exercises, as patient’s pain level allows and process as able.
- Initiate some level of proprioceptive exercise, progressing as patient’s symptoms allow. Include progression from level to uneven surfaces.
- If gait and biomechanical analysis indicates, use of lateral wedge orthotic to unload tendon area.
- Continue to re-gain flexibility, proper gait, functional ankle strength and proprioception.
- Add and advance return to work and/or return to sport simulation as patient tolerates.

Physical Therapy Operative Protocol

- Surgical interventions may include: repairs of acute rupture, repairs for chronic instability, deepening of the fibular groove, debridement and/or synovectomy of tendons, peroneal tendon transfers and reconstruction.
- Due to the number of surgical treatment options available, the physical therapist must be certain that either a detailed operative note and/or P.T. prescription with complete diagnosis is obtained.

General Post Operative Physical Therapy Guidelines

Preoperative Physical Therapy

Pre surgical Gait Training, Balance Training, Crutch Training and Knee Scooter Training

Phase I: Protect (Weeks 0-6)

GOALS:

- Patient nonweightbearing (NWB) in short leg splint x 2 weeks.
- At 2 weeks: staples removed, patient transferred to CAM boot or cast at MD discretion.
- Around 3 weeks: patient may remove boot for gentle range of motion (ROM) in planes indicated by MD.
- Formal P.T. can begin anywhere from 2-4 weeks post OP; depending on MD preference.
- Initial P.T.: Pain & edema management, AROM, start single leg stance exercises for proprioception.

Developed in conjunction with the physicians at South Bend Orthopaedics

WEEK 1: Strict elevation, NWB in splint

- Strict elevation of the leg above the heart (23 hours/day!)
- Ice behind knee (vascutherm or ice bag) to minimize swelling and control pain
- Wiggle toes, bend hip and knee to avoid muscle atrophy
-

1ST POSTOP VISIT (5-7 DAYS): dressing change, transition to boot or cast at MD discretion

- Continue to elevate, NWB
- May remove boot 4-5 times per day to work on ankle dorsiflexion/plantarflexion (up and down movements)

WEEK 2: Sutures removed

- Begin progressive WBAT in boot
- Continue active ROM
- Start physical therapy
 - o Focus on active motion, strengthening
 - o Avoid passive inversion

WEEKS 6-8:

- Normalize gait
- Isometrics with ankle in 0 DF.
- Appropriate manual therapy for normalizing talar, subtalar joint motion.
- Process proprioceptive exercises.

WEEKS 8-12:

- Transition to normal shoe. When transitioning to regular shoe, ambulate first around the house and then progress to outside with ankle stabilizing orthosis (ASO) for weeks 8-12.
- Further ankle strengthening, avoiding maximal DF, maximal eversion
- Continue to normalize gait, orthotic intervention as necessary.
- If patient has minimal to no pain, and demonstrates good form with proprioceptive exercises on level surfaces, progress to uneven surfaces

WEEK 12: Progress to work or sports related activities as appropriate.

PHYSICAL THERAPY: Start 6 weeks post op, focus on motion and swelling at first, then gait training and strengthening. At 12 weeks transition to normal shoe.

DRIVING: Prior to driving, you must be able weightbear on your right foot without crutches. If left midfoot, you may drive automatic transmission car when off narcotic pain medication

FULL RETURN TO FUNCTION: Uneven ground will be especially problematic for patients with the most significant tears. This may take 6 to 18 months. There is no guarantee on outcome. All conservative management options have risk of worsening pain, progressive irreversible deformity, and failing to provide substantial pain relief. All surgical management options have risk of infection, skin or bone healing issues, and/or worsening pain. Our promise is that we will not stop working with you until we maximize your return to function, gainful work, and minimize pain.

Steristrips are typically placed on your incision at your follow up appointment. Steristrips will typically fall off on their own. Remove steristrips in shower after 3 weeks if they remain on incision.

REFERENCES:

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